If the member refuses long term care services that have been offered, but does not wish to withdraw from the ALTCS program, the case must be referred for an evaluation of Acute Care Only eligibility via a Member Change Report (MCR) form. The member/representative must be advised that s/he could be disenrolled from the ALTCS program depending on his/her income. The MCR and a copy of the case notes or other documentation regarding the member's refusal to accept ALTCS services should be sent to the AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit.

Refer to Exhibit 1620-2 for a copy of the MCR form and to the Eligibility Manual for more information on the procedure.

Exhibit 1620-2 also provides guidelines on circumstances for which a MCR is needed and Exhibit 1620-4 describes member situations for which an Acute Care Only "D" placement is appropriate.

Q. The service plan must include the date range and units for each service authorized in the member's case file according to the Contractor's system for tracking service authorizations. Tribal Contractor case manager must enter those services authorized for the member on the CA165/Service Plan in the CATS system.

R. Service plans for members residing in an **institutional setting** must include the following types of services, as appropriate based on the member's needs:

1. Nursing facility services. The service plan must indicate the Level of Care (Level I, II, or III) based on the Uniform Assessment Tool or Ventilator Dependent status (Level IV).

2. Hospital admissions (acute and psychiatric)

3. Bed hold or therapeutic leave days (refer to Chapter 100 of this manual for definitions and limitations)

4. Services in an uncertified nursing facility

5. DME outside the institutional facility per diem (item/items with a value exceeding $300 regardless if rented, purchased or repaired). This requirement is waived for ALTCS/DD members.

6. Hospice services

7. Therapies (occupational, physical and speech)

8. Medically necessary non-emergency transportation (**required for Tribal Contractors only**)

9. Behavioral health services (only those provided by behavioral health independent billers – see definition in the Glossary of the Behavioral Health Services Guide)

10. Title XIX covered services as noted above if provided by other funding sources, for example, Medicare, Tribes, Children's Rehabilitative Services, other insurance sources.

S. Service plans for members residing in a **HCB setting** must include the following types of services, as appropriate, based on the member's needs:

1. Adult day health or group respite

2. Hospital admissions (acute and psychiatric)

3. Attendant care (separate service coding must be used to distinguish this service when provided by the member's spouse).

4. DME outside the institutional facility per diem (item/items with a value exceeding $300 regardless if rented, purchased or repaired). This requirement is waived for ALTCS/DD members.

5. Emergency alert systems

6. Medical supplies that have a monthly cost in excess of $100.00 (**required for Tribal Contractors only**)

7. Habilitation

8. Home delivered meals

9. Home health aide

10. Homemaker

11. Hospice